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Emily Schwartz

Lesley University, eschwar7@lesley.edu

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Seeking More Exposure:
A Literature Review Examining How Drama Therapy Can Be Used to Treat Posttraumatic Stress
Disorder in Adults With Diverse Learning Differences
Capstone Thesis
Lesley University

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Emily Schwartz

Drama Therapy

Jason D. Butler, PhD, RDT-BCT

Abstract

It has been suggested that adults with learning differences (LD) may be more susceptible to occurrences of violence, abuse, and neglect. However, there is presently limited research examining posttraumatic stress disorder (PTSD) in adults with LD. Within this paper, existing literature of PTSD in adults with LD is reviewed. This review includes how symptoms of PTSD in adults with LD manifest, and what treatment approaches are currently being used with the population. According to the literature, it was determined that exposure therapy is frequently used to treat PTSD in adults with LD. This result is compared with exposure elements present in drama therapy, and subsequently a discussion on how drama therapy may benefit the treatment of PTSD in adults with LD is offered. A discussion of using drama therapy with this population is then presented, focusing on the specific benefits including accessibility, safety, autonomy, and empowerment. Finally, with consideration of the unique needs of adults with LD, treatment recommendations and suggestions for future research are provided.

Keywords: learning differences, posttraumatic stress disorder, trauma, drama therapy, exposure therapy

Within the context of power, privilege, and oppression dynamics in our present society, individuals with learning differences (LD) are often experienced as invisible (Rice, Chandler, Harrison, Liddiard, & Ferrari, 2015). With this lack of visibility comes an oversight for recognizing the trauma these individuals may experience. Essentially, trauma experienced by adults with LD often goes unnoticed, because if society does not witness the population, it is as if their trauma does not exist. This message is implicitly reinforced by posttraumatic stress disorder (PTSD) in adults with LD being an under-researched topic (Mevisen & de Jongh, 2010). However, the literature indicates that adults with LD are at a greater risk of experiencing adverse life events, and thus are at a higher risk of developing PTSD (Catani & Sossalli, 2015; Harrell, 2017; Rand & Harrell, 2009). Due to the cognitive differences presented by individuals with LD, traditional treatment approaches may not be as beneficial for this population (Gilderthorp, 2015).

Within this capstone thesis, I will bring awareness to the palpable, but arguably overlooked, treatment issue of PTSD in adults with LD. I will also offer direction, informed by the literature, for treatment approaches most befitting to the specific needs of the population. Likewise, I intend to cultivate an argument supporting drama therapy as beneficial treatment for PTSD in adults with LD. Finally, I aim to encourage visibility amongst a population that is frequently unnoticed, with greater aspirations to encourage interest in, and continued research on PTSD in adults with LD.

While completing my second clinical internship to conclude my Master of Arts degree in drama therapy, I was introduced to the extraordinary students of a college transition program for young adults with diverse learning differences. This program is designed to assist young adults in their transition into independent living, not only offering them tools to secure employment, but to be able to happily and healthily live independent, fulfilled lives. Upon working with my

caseload of students in individual counseling, I discovered that a majority of these students had trauma histories--many of which had either not previously been disclosed, or had been under-addressed. Staff and faculty of the program would question why certain students struggled to get to classes on time, why they displayed frequent somatic complaints, and why they presented as overly withdrawn. Upon further examination, with clinical intentionality, these trauma histories began to surface. Although the program was well-designed to help students achieve their social, employment, and independence driven goals, the clinical needs of the students were not always being met. It is of note that this was due to no fault of the tremendously caring faculty and staff of the program. Rather, it was due to a lack of awareness which speaks to a greater systemic problem that runs rampant among this population. Despite being described as one of the most vulnerable populations, PTSD is distinctly underdiagnosed (Mevissen et al., 2016). Likewise, adults with LD cannot always advocate for themselves in ways that are heard by society, leading to a limited awareness of PTSD in this population.

I entered the program while simultaneously developing my trauma-informed drama therapeutic lens as an emerging drama therapist. Thus, I was admittedly biased to see undercurrents of trauma within the narratives my students presented. However, as our work progressed, it became clear that these narratives were very much intertwined with the challenges of showing up to classes, the somatic symptoms, and the withdrawn presentations. Merely talking about these narratives was not going to be enough, and often times wasn't quite accessible for these students given their communication differences. Yet, drama therapy presents as an accessible form of therapy for a range of populations (Johnson & Emunah, 2009), and has specifically demonstrated success with traumatized populations (Sajnani & Johnson, 2014). The more I began to implement drama therapeutic interventions with my students, the more I noticed

a decrease in their symptoms, or what staff described as unexpected behaviors. As a result, I was led with great intention to ask, how can drama therapy be used to treat PTSD in adults with diverse learning differences?

Method

This literature review examines how drama therapy can be used to treat posttraumatic stress disorder (PTSD) in adults with diverse learning differences (LD). It is influenced by the stigma put upon individuals with LD as a result of what contemporary society has deemed normal (Goodley & Runswick-Cole, 2016). The oppressive social construction of dis/ability (Goodley & Runswick-Cole, 2016) often silences individuals with LD (Mykitiuk, Chaplick, & Rice, 2015). Individuals with LD are frequently regarded as lesser than human, thus their stories do not necessarily uphold the same importance in comparison to individuals without LD (Mykitiuk, Chaplick, & Rice, 2015). This phenomenon similarly materialized in regard to the accessibility, or lack thereof, to trauma treatment for adults with LD (Mevisen, Didden, & de Jongh, 2016). Thus, this literature review aims not only to offer insight into treatment possibilities for the population, but to additionally invoke visibility upon the invisible. It aims to allow an underrepresented, and often silenced, population to be heard.

The following search terms were used in the rendering of this literature review: trauma* AND learning disabilit*; trauma* AND disabilit* AND treatment; posttraumatic stress AND learning disabilit*; trauma* AND developmental delay; posttraumatic stress AND developmental disabilit*posttraumatic stress AND disabilit* AND treatment; drama therap* OR dramatherapy) AND (exposure therapy); (mental retard*) AND (trauma OR PTSD OR posttraumatic stress); (definition OR defined) AND (learning disabilit* OR developmental disabilit* OR intellectual disabilit* OR mental retard*); (critical AND disability AND theory)

AND (intellectual AND disabilit*); normalcy) AND (intellectual disabilit*); (drama therapy OR dramatherapy) AND (intellectual* OR developmental* disabilit*); Dis/ability. The Lesley University Library database and Google Scholar were both used to complete these searches. Additionally, chapters from *Trauma-Informed Drama Therapy: Transforming Clinics, Classrooms and Communities* (Sajnani & Johnson, 2014) and *Current Approaches in Drama Therapy*, 2nd ed. (Johnson & Emunah, 2009) have been used to inform this literature review. Upon accumulating the literature, articles were sorted, reviewed, and annotated. Finally, common themes were deduced to inform how PTSD in adults with LD manifests, what the current treatment options are, and how drama therapy may beneficially supplement the treatment of the population.

Literature Review

Learning Differences Defined

Clinically, the term “learning differences” (LD) is not recognized within the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013). Rather, the *DSM-5* (APA, 2013) classifies these differences as “neurodevelopmental disorders” (p. 31), which are broadly defined as conditions that interfere with “personal, social, academic, or occupational functioning” (APA, 2013, p. 31). Yet, with consideration of the aforementioned oppression of this population, LD is the term I have chosen to use in this capstone thesis, with reasoning discussed later on in this paper. Conceptually, learning differences correlate with intellectual disabilities (ID), the term that is most often used in medical and clinical literature and practice. ID is defined as “deficits in general mental abilities and impairment in everyday adaptive functioning in comparison to an individual's age-, gender- and sociocultural matched peers” (APA, 2013, p. 37). Individuals diagnosed with an ID

often possess intellectual quotient (IQ) scores of 75 or below. However, in the latest edition of the DSM (APA, 2013), it is recognized that a single IQ score is not as useful in understanding one's intellectual abilities, and rather more comprehensive cognitive profiles should be used. Furthermore, the DSM-5 (APA, 2013) now defines the severity of ID based on adaptive functioning, as opposed to IQ scores. This corresponds with the DSM-5's (APA, 2013) restructuring of this specific diagnosis, which was previously referred as the pejorative phraseology, mental retardation (Goodley & Runswick-Cole, 2016).

Due to differences in cognition and adaptive functioning, ID frequently co-occur with other diagnosis such as specific learning disorders, autism spectrum disorder (ASD), anxiety disorders, and attention-deficit/hyperactivity disorder (ADHD). This suggests that individuals with ID are more complex than the confined definition of the diagnosis, a circumstance not contingent upon dis/abilities (Goodley & Runswick-Cole, 2016). For the purposes of research presented in this paper, LD encompasses: individuals with IQs below 80; individuals with executive functioning (EF) difficulties; individuals with cognitive differences; and individuals with conditions that may have posed difficulty in meeting developmental milestones; all of which contribute to difficulties in learning, communication, socialization, motor skills, and activities of daily living (ADLs) (Mykitiuk, Chaplick, & Rice, 2015). This paper will specifically examine adults with LD, though that is not to disregard the equally important topic of PTSD in children with LD (Catani & Sossalla, 2015).

There is a recognized difficulty in placing any label on these adults, as past and present terminology evokes pejorative undertones, and may not be congruent with the population's self-identities (Goodley & Runswick-Cole, 2016). Most of the literature examined in this paper uses the term *intellectual disabilities* to describe the population, as that is the commonplace medical,

clinical, and legal term. However, henceforth this paper will employ the term *learning differences* to discuss the population, with the exception of direct quotations. Confessedly far from perfect, the implementation of the term *learning differences* aims to offer nomenclature that celebrates “disruptive qualities” (Goodley & Runswick-Cole, 2016, p. 2) of disabilities, and that furthermore recognizes the plurality of identities these adults uphold that are not constricted to the fettered definition of disability (Gustavsson, Nyberg, & Westin, 2016).

Critical disability studies. Critical disability studies (CDS) are essentially rooted in the idea that disability is a social construction which oppresses those who are different from those in power. Likewise, those with institutional power have constructed ideas on what is perceived as normal, and what is perceived as abnormal in regard to how a human being should present (Goodley & Runswick-Cole, 2016). This endorses dis/ability as a binary, with that binary recognized with a slash (Goodley & Runswick-Cole, 2016). As a result, individuals with LD are confined to one oppressive identity, as opposed to being recognized with the plurality of identities that compose human beings (Koenig, 2012). However, CDS encourages society to “consider how we value the human and what kinds of society are worth fighting for” (Goodley & Runswick-Cole, 2016, p. 3).

Posttraumatic Stress Disorder Defined

Put simply, posttraumatic stress disorder (PTSD) is a condition of an amalgamation of symptoms that develops in response to one or more traumatic events (APA, 2013). Individuals diagnosed with PTSD repeatedly re-experience the traumatic event(s) through flashbacks, nightmares, and physiological responses, such as a rapid heartbeat, in response to reminders of the event(s) (APA, 2013). PTSD manifests through these intrusive symptoms, in addition to avoidance, negative thoughts and emotions, and physiological symptoms including: irritability,

recklessness, hypervigilance, poor concentration, and sleep disturbances (APA, 2013). It is noted that the clinical presentation of PTSD widely varies (APA, 2013), and therefore it is difficult to explicitly define the condition. Some individuals may predominantly present with fear, whereas with others, anhedonia is more predominant. Many diagnosed with PTSD display a combination of these presentations (APA, 2013).

Although recognized under a variety of other names, the comprehensive concept of PTSD is relatively new (Herman, 1997). PTSD as a formal diagnosis did not come into fruition until 1980. Pioneers in the field of trauma studies, such as Herman (1997), brought PTSD into clinical consciousness. Presently, there is an emerging awareness of PTSD and its adverse effects on trauma survivors that has materialized beyond just the counseling professions (Johnson & Sajjani, 2014). The DSM-5 (APA, 2013) recognizes the considerable comorbidity in comparison to other defined mental disorders, and furthermore discusses culture related issues of PTSD. However, within the DSM-5 (APA, 2013), PTSD in relationship to individuals diagnosed with LD is not discussed. At a surface glance, this could conceivably imply that individuals with LD do not experience PTSD, or that it is not an area of concern. Thus, there is a perpetuation of implicit societal messages of invisibility in reference to the population (Goodley & Runswick-Cole, 2016). Nonetheless, studies have shown that individuals with LD are at a higher risk of experiencing adverse life events in comparison to individuals without LD (Catani & Sossalli, 2015; Harrell, 2017; Rand & Harrell, 2009). Likewise, there is a growing recognition that PTSD in adults with LD has historically been underdiagnosed (Mevissen et al., 2016).

PTSD in Adults with LD

Notable statistics. The Bureau of Justice Statistics' (BJS) National Crime Victimization Survey (NCVS) (Harrell, 2017) examined the prevalence of nonfatal violent crimes (e.g. sexual

assault, robbery, aggravated assault) in the United States from 2009-2015 against individuals with disabilities age 12 or older. The NCVS (Harrell, 2017) concluded that individuals with disabilities were 2.5 times more likely to experience a violent crime than individuals without disabilities. Previously, according to the NCVS of 2007 (Rand & Harrell, 2009), individuals with disabilities were found to be 1.5 times more likely to experience a violent crime, possibly demonstrating an increase in crimes against this population. However, it is important to recognize that these statistics are suggestive, and may instead have alternative explanations, such as an increase in reporting of crimes. Nonetheless, the most recent NCVS (Harrell, 2017) report did conclude that individuals with “cognitive disabilities” (p. 4) were the most likely to experience a violent crime. Thus, given the distressing rates of violence against this population, it can be assumed that at least a fraction of these individuals might develop PTSD. However, considering the dearth of research on the topic (Mevisen & de Jongh, 2010), the numbers may not accurately reflect the number of adults with LD who have been exposed to a traumatic event.

In addition to findings by the NCVS (Harrell, 2017), research has suggested that individuals with LD are more likely to experience child abuse, institutional abuse, and other forms of adverse life events in comparison to the general population (Catani & Sossalla, 2015). Catani and Sossalla (2015) examined the correlation between traumatic life events and current PTSD and depressive symptoms in a random sample of individuals diagnosed with ID. Of the 56 adults in the sample size, Catani and Sossalla (2015) found that 92.9% of the participants had experienced at least one traumatic event. Furthermore, 87.5% of participants reported at least one event of child abuse in their family, 80.4% reported at least one form of institutional abuse, and 50% reported a violent physical attack occurring later in adulthood (Catani & Sossalla, 2015). These findings correlated with 69.9% of the participants reporting an event meeting the DSM-IV

criterion A of PTSD, and 25% of the participants meeting the full diagnostic DSM-IV criteria of PTSD (Catani & Sossalla, 2015).

Catani and Sossalla's (2015) findings suggest that familial stressors are the largest indicators of PTSD severity in adults with LD. In other words, early childhood trauma may lead to a continuation of traumatic events later in adulthood, due to the developed trauma responses of adults with LD. Albeit a small sample size, this study exemplifies the alarming occurrence of traumatic events experienced by individuals with LD (Catani & Sossalla, 2015). Additionally, Catani & Sossalla's (2015) findings illuminate the prevalence of clinically diagnosable PTSD in adults with LD. Nonetheless, research identifying correlations between traumatic events and clinical diagnoses in adults with LD is strikingly lacking. Part of this may be influenced by the discounting of the authentic narratives of individuals with LD (Goodley & Runswick-Cole, 2016). Society presently often relies on information as reported by caretakers, family members, or teachers, and therefore may not always be true to the inner reality of individuals with LD (Gilderthorp, 2015). As a result, conventional assessment of PTSD in adults with LD poses notable challenges.

Symptoms. Although research regarding PTSD in adults with LD is arguably in its infancy (Mevissen & de Jongh, 2010), recent studies have provided growing research delineating symptomology with this population (Hall, Jobson, & Langdon, 2014; Mevissen, Didden, & de Jongh, 2016; Mitchell & Clegg, 2005; Mitchell, Clegg, & Furniss, 2006), and argue that PTSD symptoms may in fact be more severe for adults with LD in comparison to those without LD (Mevissen et al., 2016). Mitchell and Clegg (2005) completed a focus group with clinicians who treated adults with both trauma histories and LD. Following this study, it was determined that adults with LD respond similarly to traumatic events as adults without LD, demonstrating

symptoms such as “flashbacks and nightmares; distressed by reminders; avoidance; hypervigilance and increased arousal” (Mitchell & Clegg, 2005, p. 552). However, some differences were determined, such as frequent occurrences of physical health problems and psychosomatic symptoms, and frequent “behavioural [*sic*] re-enactments” (Mitchell & Clegg, 2005, p. 552) of traumatic events. Behavioral reactions were reported to manifest as “self harm, disorganized behaviour [*sic*], agitation, fear of abandonment, withdrawal, outbursts of distress and ambivalence about relationships” (Mitchell & Clegg, 2005, p. 556). Mitchell and Clegg (2005) additionally found that adults with LD were more likely to experience multiple traumatic events, in comparison to adults without LD who were more likely to experience a single traumatic event, leading to a diagnosis of PTSD. This correlates to previous findings regarding violence against individuals with LD (Harrell, 2017; Rand & Harrell, 2009), and is of concern given the present limited recognition of PTSD in adults with LD (Mevissen & de Jongh, 2010).

Using conclusions derived from the focus group (Mitchell & Clegg, 2005), Mitchell, Clegg, and Furniss (2006) completed semi-structured interviews with five adults with LD and PTSD to more specifically identify trauma symptoms in the population. The study found that adults with LD and PTSD frequently experience psychosomatic symptoms and physical health problems; social withdrawal and isolation; and shame and guilt regarding the event(s) (Mitchell, Clegg, & Furniss, 2006). It was also determined that the participants upheld the belief that “the world is a dangerous place” (Mitchell et al., 2006, p. 134), and used avoidance as a coping strategy. However, this oftentimes presented as an inefficient strategy because for the majority of the participants, the perpetrators were also their primary caregivers, and were thus, essentially unavoidable (Mitchell et al., 2006). This dependency on perpetrators fosters confusing messages

for adults with LD regarding intimate relationships, and as a result makes it very difficult for adults with LD and PTSD to know whom they can trust.

Based on the interviews of the participants, it was also determined that adults with LD frequently blamed themselves for the traumatic event(s), harboring feelings of shame, and causing these individuals to refrain from talking about the event(s) altogether. Additionally, aspects of participants' specific LD often led to the literal inability to speak about the traumatic event(s) (Mitchell et al., 2006). This idea is perpetuated by difficulties with expressive language, which can make it difficult for adults with LD to communicate narratives of their experiences. Not only does this contribute to cultural phenomenon of trauma survivors being silenced (Sajnani & Johnson, 2014), but it also contributes to a larger phenomenon of individuals with disabilities and differences being seen as invisible, and heard as silent (Koenig, 2012). These cultural occurrences may also contribute to self-blame (Mitchell et al., 2006) by means of Fairbairn's (Flanagan, 2011) moral defense which sustains a false sense of security and control over horrendous encounters.

Similar to some manifestations of PTSD in adults without LD, it has been determined that adults with LD and PTSD may display aggression (Catani & Sossalla, 2015). However, aggression poses the risk of being seen as synonymous with the so-called "disruptive qualities" (Goodley & Runswick-Cole, 2016, p. 3) that are evident in clinical presentations of LD (APA, 2013). Thus, because it is common for adults with LD to display behaviors identified as aggressive, clinicians may misattribute symptoms to the LD, as opposed to a response to a traumatic event(s) (Tomasulo & Razza, 2007). Furthermore, PTSD symptoms have been found to manifest more atypically in adults with LD (e.g. psychosis) (Mevissen et al., 2016), therefore leading to inaccurate diagnoses. As a result, there is a continuation of incompetent treatment for

adults with LD who are also trauma survivors (Mevissen et al., 2016). Research has also indicated that PTSD symptoms in adults with LD may present as similar to PTSD symptoms in children (Tomasulo & Raza, 2007). This specifically manifests as frequent re-experiencing of the event(s), such as through distressing dreams; helplessness and guilt; re-enactments of the event(s); avoidance of stimuli associated with the trauma; and increased arousal (Mitchell & Clegg, 2005). One explanation for these similarities may be that adults with LD frequently experience processing difficulties due to cognitive differences (APA, 2013). This finding suggests that treatment approaches used with children with PTSD may also benefit adults with LD who are experiencing PTSD (Mitchell & Clegg, 2005). However, there is also risk of infantilizing adults with LD by assuming similarities with children (Koenig, 2012).

Assessment. The symptomology described above poses challenges in relation to appropriately diagnosing PTSD in adults with LD. Currently, there are no formally recognized assessments to specifically identify PTSD symptomology in adults with LD, that exist separately from assessments for the general population (Mevissen et al., 2016). Likewise, Jowett et al. (2016) recognizes that there are no standardized measures to assess trauma symptoms in adults with LD. This is arguably problematic as PTSD symptoms in adults with LD have been found to be synonymous with “challenging behaviors” (Vareenoghe & Langdon, 2013, p. 4087), thereby causing PTSD to be underdiagnosed. However, two assessments to meet the underdiagnosed needs of this population have been proposed (Hall, Jobson, & Langdon, 2014; Wigham, Hatton, & Taylor, 2011). Nonetheless, the development of these assessments is in their infancy, and would require additional trials to assess reliability and validity before they could be applied in clinical practice (Hall et al., 2014; Wigham et al., 2011). This progress toward creating an appropriate assessment for PTSD in adults with LD is notable, however there are still no formal

tools that can presently be used to adequately assess PTSD with this population. This is perhaps a contributing factor to why PTSD in adults with LD is “largely underdiagnosed and undertreated” (Mevisen et al., 2016, p. 289). Similarly, this could be argued to invoke a latent message that individuals with LD are somehow less than human (Goodley & Runswick-Cole, 2016), and therefore their trauma is not worth investigating.

Current Theoretical Orientation

Current treatment options. Given the dearth of literature on PTSD in adults with LD, limited studies have been completed to assess the efficacy of treatment for this population. However, in recent years, some pilot studies and case studies have been presented, thereby demonstrating a recognition for the importance of appropriately, and effectively, treating PTSD in adults with LD. (Vareenoooghe & Langdon, 2013). Vareenoooghe and Langdon (2013) completed a systematic review and meta-analysis assessing of the literature on psychological therapies available for individuals with LD, and their efficacy. Overall, Vareenoooghe and Langdon (2013) determined that individual therapy may be more effective than group therapy for adults with LD, although given the limited literature available, it is difficult to confidently argue this conclusion. It was also determined that cognitive behavioral therapy (CBT) approaches may be moderately effective in relation to the psychological treatment of adults with LD. However, in all the literature reviewed in the meta-analysis, many adaptations had to be made within these CBT interventions to meet the cognitive needs of the participants (Vareenoooghe & Langdon, 2013). Furthermore, Vareenoooghe and Langdon (2013) emphasize that these adaptations were not always adequately described in the studies reviewed, therefore putting the efficacy of the treatment interventions into question.

Although this meta-analysis primarily focused on the treatment of other issues, such as anger, depression, and “challenging behaviors” (Vareenoghe & Langdon, 2013, p. 4087), the results could potentially inform treatment interventions and practices for adults with PTSD. Furthermore, the treatment issues described align with the manifestation of PTSD in adults with LD (Tomasulo & Razza, 2007). Vareenoghe and Langdon (2013) did briefly discuss PTSD as a specific treatment issue and expressed that “only case studies reporting on the successful treatment of PTSD could be identified and it was concluded that currently no empirically validated treatment is available” (p. 4087). This indicates sparsity within the literature, and may arguably imply that these issues are not as high of concern in comparison to adults without LD. Thus, there exists a risk of perpetuating stigma associated with the population (Goodley & Runswick-Cole, 2016). However, the existing literature does recognize the present shortage of treatment options, and moreover emphasizes the necessity of providing quality treatment for the population (Mevissen, Lievegoed, & de Jongh, 2011a; Mevissen, Lievegoed, Seubert, & de Jongh, 2011b; Mevissen, Lievegoed, Seubert, & de Jongh, 2012). Many of the case studies that explored PTSD and LD implemented eye movement desensitization and reprocessing (EMDR) therapy (Barrowcliff & Evans, 2015; Dilly, 2014; Fernando & Medlicott, 2009; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012). A pilot study implementing trauma-focused CBT (TF-CBT) has also been completed (Kroese et al., 2016). Both of these approaches employ modified exposure methods to facilitate treatment.

Eye Movement Desensitization and Reprocessing. EMDR has been recognized as one of the leading treatment methods for PTSD given its empirical evidence (Mevissen, et al., 2011a). Put simply, EMDR therapy exists on the premise of desensitization to memories of traumatic events by employing repeated bilateral eye movements by means of finger tracking (Shapiro,

2001). Other methods of external bilateral stimulation are sometimes applied in EMDR therapy, such as “hand tapping, audio tones, or tactile buzzers” (Jowett et al., 2016, p. 710). Theoretically, the therapy is grounded in the idea that traumatic memories are not adaptively processed, thereby inducing distressing PTSD symptomology. However, it is recognized that specific mechanisms involved in EMDR therapy are sustained by a working hypothesis (Shapiro, 2001). Thus, the specific elements of EMDR that have demonstrated favorable treatment results are arguably unknown (Jowett et al., 2016). Shapiro (2001) argues that traumatic memories become “dysfunctionally locked” (p. 41) physiologically, and that physiological elements are thereby necessary to free traumatic memories so that they may be adaptively processed. Ideally, adaptive information processing in relationship to EMDR allows for individuals to reprocess traumatic events while accessing their working memory, initiating an overall desensitization to distressing memories and a reduction, or even dissipation, of PTSD symptoms (Shapiro, 2001).

Standard EMDR therapy employs an eight-phase treatment model, sequentially, as follows:

1. Client history
2. Preparation
3. Assessment
4. Desensitization
5. Installation (integration of processing into self-concept and cognition)
6. Body scan
7. Closure
8. Re-evaluation (assessment of treatment, review of symptomology, and identification of any ensuing unprocessed memories) (Shapiro, 2001).

Within EMDR psychotherapy, phases three to six are primarily involved with the reprocessing of the traumatic memory (Mevissen et al., 2011b). During these stages, clients are asked to focus on the most distressing element of the traumatic memory, will simultaneously focusing on the external bilateral stimuli (Mevissen et al., 2011b). Focusing on the bodily sensations that accompany the distressing imagery of the traumatic memory is additionally an important component of the EMDR process (Shapiro, 2001). It is hypothesized that this process induces “access to the emotional and somatic aspects of the memory” (Mevissen et al. 2011b, p. 275), thereby allowing for the memory to cognitively and psychologically become reprocessed. Likewise, it is argued that by recalling the traumatic event while executing another task (tracking external bilateral stimuli), the working memory is engaged, and the memory becomes processed as less vivid and emotional (Mevissen et al., 2011b). Thus, a desensitization process is induced.

Regarding the treatment of PTSD in adults with LD, the literature is predominantly composed of case studies implementing variants of EMDR with the population (Barrowcliff & Evans, 2015). Because EMDR requires little verbal communication from the client, it has been recognized as a favorable treatment approach for adults with LD. However, much of the literature fails to explicitly describe how EMDR was adapted to meet the unique needs of the population (Gilderthorp, 2015). As a result, it is difficult to understand the scope of EMDR as a treatment intervention for PTSD in adults with LD. Likewise, Jowett et al. (2016) assert that presently, there is no standardized method for using EMDR to treat PTSD in adults with LD. The literature discusses a variation in the types of bilateral stimulation used as a part of administering EMDR therapy including: the traditional visual bilateral stimulation, auditory bilateral stimulation, and tactile bilateral stimulation (Jowett et al., 2016). However, Gilderthorp (2015) identifies that each of these case studies display a shortcoming in discussing which type of

bilateral stimulation was the most effective in treating the population. Thus, overall, it is challenging to assuredly assess the efficacy of EMDR as a treatment approach. Nevertheless, all cases presented in the literature display favorable results from implementing EMDR interventions, with each case displaying a reduction in PTSD symptoms, some cases displaying a vanishing of PTSD symptoms altogether, and no reporting of adverse effects from treatment (Jowett et al., 2016).

Although not always described in detail, there is a manifestation of common themes regarding modifications to the EMDR approach with adults with LD. These themes include: simplified language, implementing physical gestures, employing use of visual cues, and engaging the client's caretaker(s) as a co-therapist (Mevisen et al., 2011a). Dilly (2014) describes the application of visual cues extensively in a case study implementing an EMDR approach. Due to differences in verbal communication, Dilly (2014) found that it was beneficial to have Simon, the case participant, draw images of the traumatic event. This differs from traditional EMDR protocol (Shapiro, 2001). Furthermore, Dilly (2014) employed the use of "symbol cards" (p. 65) to elicit Simon's communication of thoughts, emotions, and physical sensations. Various other case studies in the literature describe the benefits of using visual cues, including drawings, to aid communication about thoughts and emotions, in addition to aiding mental visualization of the traumatic memories (Barrowcliff & Evans, 2015; Mevisen et al., 2011a; Mevisen et al., 2011b). However, the interventions are often not described in detail, thus it is difficult to conceptualize how these visual cues were specifically employed. Mevisen et al. (2011a) also discuss benefits of using dramatized physical gestures while eliciting EMDR therapy to augment communication. Within each of these case studies, results were described as favorable, with all participants exhibiting significant decrease, or disappearance, of PTSD

symptoms altogether following treatment. Likewise, in each study it is described that these results were maintained in treatment follow up studies ranging from 3 months to 2.5 years in length (Barrowcliff & Evans, 2015; Dilly, 2014; Mevissen et al., 2011a).

A common adaptation present in the literature of using EMDR to treat PTSD in adults with LD is employing the use of Lovett's (1999) Story Telling Method (Barrowcliff & Evans, 2015; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012). The Story Telling Method is an adaptation of EMDR to treat children who have experienced trauma. The method involves having the parent or caretaker describe the traumatic event(s) while the therapist engages the client in the EMDR bilateral stimulation process. Lovett (1999) discusses that EMDR was not as effective for children with LD in comparison to children without LD, as many symptoms in children with LD continued to manifest following the treatment process. Protocol for this method as described in the literature requires the involvement of parents or caregivers, essentially as co-therapists as a part of the treatment process (Gilderthorp, 2015). Although the treatment results are described as favorable (Barrowcliff & Evans, 2015; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012), this approach does raise some ethical concerns discussed later in this paper (Gilderthorp, 2015).

The most beneficial part of implementing EMDR to treat PTSD in adults with LD appears to be the elements of invoking a safe place (Dilly, 2014). Within traditional EMDR protocol, identifying a safe place is a part of the preparation stage (Shapiro, 2001). The literature discusses using images, drawings, or objects as projective tools to invoke the physical sensations and visualizations that accompany the identified safe place (Barrowcliff & Evans, 2015; Dilly, 2014). Dilly (2014) discussed closing every session by sharing a visual image of Simon's identified safe place, and Simon shared that this ritual was a particularly useful part of the

treatment process. Given that this population often displays rigidity and need for consistent routine, the reliability of closing with a predictable ritual may evoke an added element of safety (Dilly, 2014). This is important when working with individuals with PTSD, especially those whose communication abilities may be different. Likewise, invoking safety is important when considering the possibility of re-traumatization (Gilderthorp, 2015).

Despite the variance in modifications of EMDR interventions implemented, the common thread between the success of all of the cases seems to be the element of exposure. Each case study involved exposure to the traumatic memory(s) in some way, be it through visuals, a retelling of the experience(s) by a caretaker, or a combination of the two (Barrowcliff & Evans, 2015; Dilly, 2014; Jowett et al., 2016; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012). The continued exposure to the traumatic memory(s) theoretically induces desensitization to the memory(s), causing the supplementary physical sensations, thoughts, and emotions to become more tolerable. Likewise, a reduction in PTSD symptomology is induced (Shapiro, 2001).

Trauma-Focused Cognitive Behavioral Therapy. Trauma-focused cognitive behavioral therapy (TF-CBT) is a derivative of cognitive behavioral therapy (CBT) in which the objective of treatment is to specifically reduce stress regarding a traumatic event(s) (Bisson et al., 2013). This is practiced through a variety of techniques aimed at transforming cognitions, or thoughts, and behaviors, or actions. Likewise, TF-CBT employs exposure to traumatic memories as a part of treatment (Bisson et al., 2013). According to the Cochrane Review (Bisson et al., 2013), TF-CBT is presently recognized as one of the most efficacious treatment approaches for adults with PTSD. However, it has been recognized that standard CBT methods are difficult to use with individuals with LD due to cognitive differences (Kroese et al., 2016). Despite this, two studies

used cognitive restructuring combined with exposure therapy to treat PTSD in adults with LD (Fernando & Medlicott, 2009; Lemmon & Mizes, 2002). Both studies demonstrated favorable results. To further evaluate the efficacy of TF-CBT specific interventions, Kroese et al. (2016) completed a pilot study implementing modified TF-CBT approaches with adults with LD.

The pilot study employed a group format because it was determined by the researchers that “participants with ID find peer interactions and support helpful” (Kroese et al., 2016, p. 300). To date, there is no existing literature evaluating the efficacy of individual TF-CBT for the population. The goal of the pilot study group was to offer a space where the PTSD survivors could “practise [sic] developing safe and trusting relationships with themselves and others” (Kroese et al., 2016, p. 301). Furthermore, the study aimed to offer participants with strategies to re-create safety, and to invoke affect regulation. Likewise, the study offered a psychoeducational component, with intentions of informing the participants of how trauma impacts the body. Kroese et al. (2016) assert that all the participants consented to be a part of the study, however this process is not described in detail. Thus, it is difficult to assess if genuine consent was received from the participants themselves, or if consent was obtained from the caregiver(s). Regardless, Kroese et al. (2016) imply that assent between the participants and the study was sincerely obtained.

Several common themes emerged upon completion of the study, which were determined based on post-study interviews with the participants. One major theme identified was “being listened to” (Kroese et al., 2016, p. 303). The interviews with the participants suggested that many of them had previously felt silenced throughout their lives, and that it was affirming to be heard. Furthermore, the participants “expressed their surprise at being taken seriously” (Kroese et al., 2016, p. 303), as they had become accustomed to commonly being dismissed. In addition

to being heard by the therapists involved in the study, the participants found comfort in being heard by other group members. The participants valued the connections made with each other (Kroese et al., 2016). However, they did identify “being in a group can be stressful” (Kroese et al., 2016, p. 303). This seemed to arise from the intensity of having to hear the recounted details of each participants’ story, thus heightening anxiety around the traumatic events (Kroese et al., 2016).

Kroese et al. (2016) allowed space for the participants to reflect on their experience in the study and offer suggestions in regard to the group. Participants shared that they would’ve liked to have more opportunities to create artwork and participate in role-plays, as those were identified as the participants’ favorite parts of the group. The participants also suggested to “avoid information over-load” (Kroese et al., 2016, p. 306). This comment was in reference to the psychoeducational components of the group. The participants shared that the way in which information was presented was too overwhelming to understand, likely due to the cognitive differences of the given population (APA, 2013).

In addition to participants’ reflections, the researchers completed their own reflections in response to the pilot study (Kroese et al., 2016). Kroese et al. (2016) recognize that some practices completed in the pilot study were not necessarily sensitive to the needs of the participants. For example, Kroese et al. (2016) discuss demanding that group members engage in certain tasks, such as closing eyes, as opposed to providing options, or assessing the comfort level of the participants. These actions are arguably aligned with ideas that negate the autonomy of adults with LD (Koenig, 2012), and assume compliance of the population as opposed to providing them with choice. Similarly, it was observed that “some of the support staff acted inappropriately, belittling their clients, undermining their confidence and disclosing confidential

information” (Kroese et al., 2016, p. 307). Not only does this observation oppose any sense of safety that may have been provided for the participants within the group, but it additionally emphasizes preexisting stigmas associated with the population that perpetuate diminished autonomy.

Fernando and Medlicott (2009) completed a case study using cognitive restructuring and exposure therapy to treat PTSD symptoms in a young woman with a LD. The specific interventions used were influenced by TF-CBT, but were sometimes modified to meet the needs of the participant. A major component of treatment involved helping the participant to reframe automatic negative thoughts (ANTS). Within the case study, Fernando and Medlicott (2009) describe employing the metaphor of “squashing the ants” (p. 189). This metaphor was amplified by encouraging the participant to “squash the ants” by using a shield. In session, the participant was given the opportunity to artistically create a paper shield to concretize the metaphor. The paper shield was then encompassed throughout sessions as a projective tool for the participant’s coping skills and encounters with the ANTS. In addition to cognitive restructuring interventions, Fernando and Medlicott (2009) employed the use of exposure. It is discussed that there was much consideration of the possibility of retraumatization, and as a result, imaginal exposure was used. During this intervention, the participant was asked to imagine her flashbacks, or as she identified them, “flickers” (p. 189). Fernando and Medlicott (2009) describe embodying the flickers and encouraging the participant to use her shield to defend herself. Results of treatment were favorable, and the occurrence of flashbacks vanished “following the session where the flickers were enacted” (Fernando & Medlicott, 2009, p. 189). Thus, it is conceivable that the use of metaphor and embodied interventions may have positively influenced the participant’s overall treatment.

This intervention arguably demonstrates themes and practices commonplace to drama therapy. Fernando & Medlicott (2009) essentially employed distancing (Landy, 1997) to engage the participant with traumatic material. Likewise, it is arguable that the use of projectives evoked safety and structure in an exposure process that was accessible for the participant. The researchers assert that their implementation of dramatic reenactment “may have resulted in cognitive restructuring that made her [the participant] believe she was in control and able to cope” (Fernando & Medlicott, 2009, p. 191). Thus, it is viable that this intervention provoked autonomy and empowerment. Given these results of the case study, Fernando and Medlicott (2009) recognize that “further research could examine the efficacy of using alternative forms of exposure with people with intellectual disability [sic]” (p. 191). Drama therapy may perhaps offer this alternative mode of exposure therapy to treat PTSD in adults with LD.

Drama Therapy

In comparison to traditional psychotherapy methods, drama therapy is active and experiential, engaging both mind and body simultaneously (North American Drama Therapy Association [NADTA], 2018). Unlike most psychotherapy approaches, drama therapy is not exclusive to verbal processes. Rather, drama therapy operates on an integration of verbal, cognitive, and somatic processes (Jones, 2007). In other words, drama therapy aims to foster a mind and body connection. These methods distinct to drama therapy invite a psychotherapeutic experience that may allow for more appropriate, comprehensive treatment of PTSD in adults with LD.

Drama Therapy and Adults with LD. It is important to recognize that there is quite expansive drama therapy literature specifically focused on working with individuals with LD (Bailey, 2009; Bailey, 2010; Bailey 2016; Snow, D’Amico, & Tanguay, 2003; Snow, 2009;

Snow et al., 2017). The interventions discussed in this literature most often employ therapeutic theatre, or theatre arts within classroom settings. Snow et al. (2003) discusses therapeutic theatre interventions performed at the Centre for the Arts in Human Development at Concordia University in Montreal. The Centre is a “multimodal clinical program” (Snow et al., 2003, p. 76) that engages with the use of creative arts therapies with individuals with “a variety of developmental disabilities” (p. 76) for therapeutic and research purposes. In discussion of therapeutic theatre processes at the Centre, Snow et al. (2003) considers the benefits of establishing a “therapeutic community” (p. 78). Given Snow et al.’s (2003) findings, this process has produced favorable results, specifically with themes of: increased socialization, teamwork, gains in self-confidence, empowerment, and increased spontaneity. Bailey’s (1993; 2009; 2010) work, which often explores the use of theatre arts with individuals with LD in classroom settings, has demonstrated similar findings. However, the majority of this work is focused on reducing stigmas present in relationship to individuals with LD (Bailey, 2016). Likewise, the intentions of this drama therapy work appear to be focused on integration and empowerment (Bailey, 2010; Snow et al., 2003; Snow 2009; Snow et al., 2017). While these are encouraging aims for the therapeutic process of working with adults with LD, there is little to no discussion of how to engage with the population when more extensive challenges may also be present, such as PTSD.

Two case studies were found within the literature that implemented drama therapy interventions to treat acute emotional issues in adults with LD (Feniger-Schaal, 2016; Folostina et al., 2015). Although there is no discussion of the presence of trauma histories or prominent adverse life events in either case study, this is the only research found to use drama therapy in domains beyond inclusion and community arts. Likewise, these studies arguably make more intentional encounters with the deep-seated emotional concerns that may also be present with the

population. Although Snow et al. (2017) and Bailey (1993; 2009; 2010) graze these issues, they never quite make contact in regard to drama therapeutic treatment interventions. However, the two case studies described above contribute drama therapy interventions to treat specific concerns of adults with LD. Both case studies employ storytelling methods, and both describe favorable results (Feniger-Schaal, 2016; Folostina et al., 2015).

Feniger-Schaal (2016) completed a case study using drama therapy to treat an adult dually diagnosed with a LD and an anxiety disorder. Adverse life experiences are not specifically detailed, however the case participant, David, is described as “lonely and isolated” and “helpless, anxious, and lost” (Feniger-Schaal, 2016, p. 41). Feniger-Schaal (2016) engaged with story-making while working with David as a means of empowering him with the agency to express his inner reality. David’s LD presented a variety of communication differences, thereby underscoring drama therapy as an encouraging approach. Feniger-Schaal (2016) employed the use of visual cards to facilitate the story-making process. Upon completion of the intervention, themes of loneliness and desire for companionship were determined. Feniger-Schaal (2016) asserts that the drama therapy intervention served as “an opportunity [for David] to begin processing these issues” (p. 44). Likewise, it is conceivable that the creation process between the therapist and David served as a reparative relationship that encouraged the development of pathways for him to overcome his loneliness and helplessness. This is supported by diminishment in David’s symptoms following the drama therapy intervention. Based on the results of the study, Feniger-Schaal (2016) determined that drama therapy “endowed the metaphoric language that enables a rich communication despite disability” (p. 44). Nonetheless, it is important to consider the potential dangers of communicating entirely in metaphor, as these methods are highly interpretational. Furthermore, it may encourage power constructs to manifest,

as power is placed in the hands of therapist, whose job it becomes to analyze the meaning of the story, potentially playing out the enduring narrative of adults with LD being silenced. And so, emerges the question: How can one authentically assess the congruence of the metaphor with the individual's' actual inner experience? --particularly when a communication difference is also present.

Drama Therapy and PTSD. In recent years, there has been an attentive action to develop supportive, trauma-informed approaches within the field of drama therapy (Sajnani & Johnson, 2014). Although one could argue that the nature of drama therapy is inherently trauma-informed, distinct measures have been taken to more fully cultivate drama therapy methods specific to the treatment of PTSD. Likewise, the literature demonstrates an interest in understanding and identifying why drama therapy exists as an effective approach for treating PTSD (Sajnani & Johnson, 2014). Nevertheless, the variety of drama therapeutic approaches for treating PTSD is broad. However, distinct elements of drama therapy have been commonly identified across these variety of approaches that contribute to trauma-informed drama therapy. Of these elements, the following correlate most appropriately in treating PTSD in adults with LD: safety, play, role reversal, psychological distance, and following the lead of the client (Sajnani & Johnson, 2014).

Dramatic metaphor exists as a foundational principle upon which drama therapy is built (Jones, 2007), where frightening realities can be experienced in a parallel, protective realm (Frydman & McLellan, 2014). The safety that metaphor encourages discerns drama therapy as a unique approach for treating trauma (Sajnani & Johnson, 2014). Likewise, drama therapy intentionally invokes psychological distance, or as is referred to in drama therapy literature, aesthetic distance (Landy, 1997) Aesthetic distance can be understood as a synchronous thinking

and feeling space in which an optimal balance exists between cognition and emotional expression. However, the drama therapist has tools to manipulate this distance. For example, if a client is affectually disconnected from the trauma, or overdistanced, specific interventions may be performed to heighten the affectual experience. Likewise, if a client is emotionally flooded, or underdistanced, specific interventions may be performed to encourage cognitive reflection (Landy, 1997). The drama therapist's ability to manipulate this distance within an imaginative, metaphoric realm fosters a sense of safety and security, a primary need for trauma survivors (Sajnani & Johnson, 2014), while additionally having the capability to challenge clients as a means of cultivating therapeutic growth. One may argue that TF-CBT interventions may equally uphold the capacity to engage a client in the process of psychological distancing. However, these interventions are often constrained solely to the boundary of one's mind. Drama therapy may offer tools capable of extending this boundary, encompassing mind and body, and likewise offering playfulness within the safety of an imaginative space. Respectively, "the therapist has a greater capacity to control a gradual exposure experience for the client" (Johnson & Sajnani, 2014, p. 17).

Exposure. Johnson and Sajnani (2014) argue that trauma-informed drama therapy implements imaginal exposure. Yet, they additionally assert that drama therapeutic tools move imaginal exposure beyond the containment of one's mind by engaging dramatic re-enactment. This conceivably "provides far more vividness of recall through the engagement of the physical body and the entire sensory system" (Johnson & Sajnani, 2014, pp. 16-17). Likewise, Johnson & Sajnani (2014) discuss that "vividness of recall has been empirically shown to be the most important element in successful desensitization" (p. 17). Thus, by allowing for a full sensory experience within dramatically embodied exposure in relationship to traumatic events, there is

potential for a greater transformation to ensue. Not only is the client becoming desensitized to thoughts, feelings, and memories, but they are also becoming desensitized to bodily sensations, somatic responses, and sensory experiences that may be associated with the traumatic event(s). Shapiro (2001) in fact discusses the importance of incorporating a body scan into trauma treatment, and it is a part of the EMDR eight phase model. Rather than addressing cognitive, affective, and bodily experiences as separate, drama therapy offers an integrative approach (Sajnani & Johnson, 2014). Developmental Transformations (DvT), as a specific method of drama therapy, is “aligned with evidence-based practices in the treatment of trauma” (Sajnani & Johnson, 2014, p. 26). Likewise, trauma-focused DvT is arguably a model of drama therapy that is most congruent with exposure and desensitization practices (Pitre, Sajnani, & Johnson, 2015).

Developmental Transformations. Developmental Transformations (DvT) is an action-oriented form of drama therapy that employs the use of improvisation and embodiment as an approach to psychotherapy (for a comprehensive discussion, see Johnson, 2009). According to Johnson (2009), DvT is characterized by “the process and dynamics of free play” (p 89), deriving inspiration from psychoanalysis, object relations, client-centered therapy, existentialism, dance/movement therapy, and Buddhism. Aligned with free association (Johnson, 2009), DvT facilitates improvised, spontaneous play in which both client and therapist engage in a “free-flowing manner” (Butler, 2012, p. 89). Rather than engaging in verbal and literal discussion of thoughts and feelings, the client is encouraged to express their inner experiences through dramatic embodiment, sounds, enactments, and images based on the present moment (Johnson, 2009). As a result, the moment to moment improvisational play shifts, changes, and transforms mirroring the internal shifts, changes, and transformations of the client’s thoughts and feelings.

DvT recognizes that “being is unstable” (Johnson, 2009, p. 90), challenging humanity’s conventional comfort in stability, coupled with a yearning for repetition. These rigidities and attempts to control the instability of being (Johnson, 2009) are often more pronounced in adults with LD (APA, 2013). Nonetheless, most forms of therapy offer tools to engineer a facade of stability. DvT, however, contradicts this approach, and instead provides tools to directly cope with the instability intrinsic to the human experience (Johnson, 2009). A distinguishing element of DvT is that the therapeutic session occurs within the playspace. Contrary to its name, the playspace is not a literal location, but rather it is a mutual agreement between the DvT practitioner and the client. The playspace evokes a liminal space in which reality and imagination align, but never quite touch. In this way, it is argued that the playspace is compatible with Landy’s (1997) concept of aesthetic distance (Johnson, 2009).

Trauma-centered DvT employs the basic concepts of the method, as outlined above. However, given its intention of trauma treatment, specific measures are taken to align the implementation of DvT with exposure practices. Within the playspace, the client is gradually exposed to traumatic material as a means of activating habituation, thereby initiating symptom reduction (Pitre, Sajjani, & Johnson, 2015). Pitre et al. (2015) argue that the “highly embodied play” (p. 43) that characterizes DvT may strengthen the desensitization process in comparison to other exposure-based therapies. Likewise, Pitre et al. (2015) argue that the imaginal exposure performed by DvT invokes a more “concretized foundation” (p. 43) in regard to treatment. Thus, not only is the client activating cerebral processes when re-imagining traumatic memories, but they are additionally activating kinesthetic and sensory experiences through embodied re-enactment. Accordingly, PTSD survivors are able to physically practice desensitization, aside from solely imagining these practices within their minds. For adults with LD, this has the

potential to be especially beneficial due to the population's proclivity toward concrete thinking (APA, 2013). Johnson (2009) states that "DvT has great overlap with many other drama therapy approaches that utilize improvisation in a developmentally-informed manner that matches the dramatic expression with the abilities and needs of the clients" (p. 99). Thus, DvT as a treatment approach can transform moment by moment, attuning to the specific needs of each client within a developmental framework. Given the unique needs of adults with LD, Johnson's (2009) assertion of DvT's accessibility reinforce the approach's presentation as advantageous for the population.

Discussion

After reviewing the literature, it is apparent that PTSD is a discernible treatment issue for adults with LD that warrants clinical attention (Mevissen et al., 2016). To date, common PTSD treatment methods such as EMDR and TF-CBT have been used with the population (Barrowcliff & Evans, 2015; Dilly, 2014; Fernando & Medlicott, 2009; Kroese et al., 2016; Lemmon & Mizes, 2002; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012). However, after examining the literature, it is also probable that drama therapy may offer benefits in treating this population, specifically in regard to providing accessibility, maintaining safety, and encouraging autonomy and empowerment. EMDR and TF-CBT have been recognized as the leading methods to treat PTSD (Bisson et al., 2013), and accordingly these methods have been applied to the treatment of PTSD in adults with LD (Barrowcliff & Evans, 2015; Dilly, 2014; Fernando & Medlicott, 2009; Kroese et al., 2016; Lemmon & Mizes, 2002; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012). These methods mutually share the employment of exposure practices as a mode of habituation in response to the discomfort surrounding traumatic experiences. Based on the existing case studies presented in the literature,

results from these treatment practices are favorable (Barrowcliff & Evans, 2015; Dilly, 2014; Fernando & Medlicott, 2009; Kroese et al., 2016; Lemmon & Mizes, 2002; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012). However, EMDR and TF-CBT aim to encourage individuals to talk about their trauma. This may not always be accessible for adults with LD (Vareenoghe & Langdon, 2013). Likewise, verbal processing may not be the most beneficial mode of facilitating treatment given the population's processing and communication differences (Mykitiuk et al., 2015).

The literature suggests that participants most enjoyed the creative elements of treatment, such as artwork and role-plays (Kroese et al., 2016). Similarly, Fernando and Medlicott (2009) surmised that their creative, embodied intervention was central to the recovery of their case participant. These findings suggest that adults with LD may be more receptive to creative interventions as opposed to traditional treatment modalities for PTSD. Drama therapy may offer creative exposure interventions beneficial to treating the population (Johnson & Sajnani, 2014).

Benefits of Drama Therapy

Through the implementation of theatrical tools, drama therapy may offer more accessible treatment to the population given the potential communication and processing differences that are evident in clinical manifestations of LD (APA, 2013). Because drama therapy employs embodied interventions, and offers alternate ways to explore difficult material, it has the potential to be an operative treatment for the population. EMDR and TF-CBT rely primarily on verbal instructions (Bisson et al., 2013; Shapiro, 2001). In contrast, the embodied qualities innate to drama therapy may have the capacity to offer a shared method of communication, as opposed to only implementing forms of communication that may be challenging for the population (Johnson & Sajnani, 2014). Likewise, offering more accessible modes of communication when

treating PTSD in adults with LD allows for the opportunity to transform objectionable messages of power. Only communicating in verbal contexts that are difficult to process for adults with LD may incite the message: my form of communication is superior to yours. Not only does this pose risk of perpetuating present stigmas regarding adults with LD (Goodley & Runswick-Cole, 2016), but it is also congruent with the perpetrator and survivor relationship relative to PTSD (Johnson & Sajnani, 2014).

Accessibility. The literature generally determined that extensive verbal processing, as was executed in the TF-CBT and EMDR methods discussed, was oftentimes too overwhelming for the population (Dilly, 2014; Fernando & Medlicott, 2009; Kroese et al., 2016). Moreover, this was explicitly expressed by the participants themselves (Kroese et al., 2016). This correlates to the overall cognitive processing differences of the given population. Drama therapy interventions may have the potential to offer alternate modes of communication that do not rely solely on verbal communication and processing (Sajnani & Johnson, 2014). This may manifest through means of embodiment, play, and metaphor. Likewise, embodied elements innate to drama therapy may provide adults with LD with a more concrete understanding of how trauma manifests within the body. Accompanying this is an invitation to learn to tolerate difficult and uncomfortable bodily experiences and symptomatology in a safe space (Johnson, 2009).

Accordingly, when these sensations occur outside of the playspace (Johnson, 2009), adults with LD may be better equipped to respond to these PTSD symptoms. Because PTSD in adults with LD has been found to manifest primarily through psychosomatic symptoms (Mitchell & Clegg, 2005), embodied treatment may moreover provide additional benefits.

With drama therapy comes a variety of treatment tools that are not contingent upon verbal processing. Thus, there exists the capacity to meet the communication needs of the clients,

as opposed to expecting the clients to comply with what communication standards society has set for normalcy (Koenig, 2012). Drama therapy therefore may benefit adults with LD by providing accessible treatment for PTSD that additionally has the capacity to deconstruct the present, commonly accepted dis/ability narrative (Goodley & Runswick-Cole, 2016).

Safety. Conclusively, the literature acknowledges the paramount need for safety when treating PTSD in adults with LD (Barrowcliff & Evans, 2015; Dilly, 2014; Fernando & Medlicott, 2009; Jowett et al., 2016; Kroese et al., 2016). Similarly, the literature found that directly verbally addressing traumatic memories was oftentimes too overwhelming for the population, and could escalate to a disarray of emotional flooding and sensory reliving too overpowering for clients to effectively process (Barrowcliff & Evans, 2015). Jowett et al. (2016) best acknowledges this phenomenon by stating, “the therapist found that the client’s whole traumatic memory was immediately too overwhelming to attend to” (p. 175). To remedy this, the literature suggests employing distancing techniques, rituals, and reliable closures (Barrowcliff & Evans, 2015; Dilly, 2014), all of which foster a sense of safety and containment.

Distancing techniques were implemented throughout the literature to provide safety (Barrowcliff & Evans, 2015; Dilly, 2014; Fernando & Medlicott, 2009), and were regarded as “particularly useful” (Dilly, 2014, p. 66). This evokes a noteworthy correlation to aesthetic distance (Landy, 1997), and distancing practices central to drama therapy. Within the literature, it could be argued that the direct detailing of traumatic events was cognitively too overwhelming for participants to process (Jowett et al., 2016; Kroese et al., 2016), thereby eliciting the need for distance to establish safety. Because drama therapy is rooted in metaphor, distance is inherent to the process, thereby invoking safety. Thus, drama therapy may offer effective treatment for adults with LD by allowing the revisiting of traumatic material to become more tolerable.

Frydman and McLellan (2014) support this assumption, as they argue that the metaphor-based drama therapy interventions they implemented induced executive functioning (EF) improvements. As discussed by Frydman (2017), the imaginary space invoked by the drama therapeutic intervention essentially serves as a “hyper-container” (p. 112) in relationship to receiving and responding to stimuli. Thus, while the reception of and responses to stimuli are very much real, a greater level of tolerance is presented with drama therapy. This is because clients are not asked, nor expected to directly control traumatic memories, but in contrast, are invited to playfully encounter traumatic material within the healing capacities of metaphor (Frydman & McLellan, 2014).

Autonomy and Empowerment. As the literature suggests, trauma-informed drama therapy offers treatment that is often aligned with evidence-based practices (Sajnani & Johnson, 2014). Yet, the prevailing methods of trauma treatment, such as EMDR (Shapiro, 2001) are linear and essentially rely on the therapist taking the lead. Given the power upheld by the therapist, this may pose the risk of perpetuating societal messages of viewing adults with LD as somehow lesser than human (Goodley & Runswick-Cole, 2016). On the contrary, drama therapy often relies on the client taking the lead “as they engage with the creative process” (Sajnani & Johnson, 2014, p. 34). Likewise, trauma-informed drama therapy interventions, such as trauma-centered DvT are not necessarily linear, thereby more accurately aligning with the human experience (Sajnani & Johnson, 2014).

By offering a more directorial role for the client, as drama therapy often does, (Sajnani & Johnson, 2014), adults with LD are provided a space for empowerment to develop. Correspondingly, the drama therapist can then serve as a witness. This entails holding and containing the difficulties and complexities tangled within tangential narratives of trauma.

Respectively, this cultivates a space for adults with LD to righteously be seen and heard, a fundamental component to positive outcomes in treating PTSD with the population (Kroese et al., 2016). Likewise, the literature found that fostering a sense of control was key to the recovery of PTSD in adults with LD (Fernando & Medlicott, 2009). Furthermore, this was accomplished through dramatic interventions. Despite these findings, Lovett's (1999) Story Telling Method (Barrowcliff & Evans, 2015; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012) is still the most commonly implemented adaptation of EMDR when treating PTSD in adults with LD. As the literature discusses, this entails the parent or caregiver sharing the trauma narrative as opposed to the client. Thus, the client is left to surrender their authentic experience of their story to the subjective interpretation of another (Gilderthorp, 2015). Lovett (1999) explicitly recognizes that the children treated within her method were essentially powerless, and that EMDR would not restore power to them. One could argue that this provokes a loss of control, an all too familiar narrative not only for trauma survivors (Johnson & Sajani, 2014), but additionally for adults with LD, as society's standards for normalcy (Koenig, 2012) can leave adults with LD feeling powerless.

A space for the authentic voices for adults with LD to be heard is imperative to initiate the healing process. This was specifically professed by participants throughout the literature (Kroese et al., 2016). In fact, the participants explicitly expressed astonishment "at being taken seriously" (Kroese et al., 2016, p. 303) given the commonplace silence they had grown accustomed to. Similarly, being offered a safe space for the trauma narratives of participants to be heard and supported was deemed fundamental to the quality of treatment. Placing power in that hands of another, as the Story Telling Method (Lovett, 1999) often does, can infringe upon this process. However, the creative processes of drama therapy may offer the autonomy

necessary to treat PTSD in adults with LD. Drama therapy as a treatment approach to PTSD in adults with LD offers safety, and likewise accessible communication and treatment that is not confined to society's standards of normalcy. Consequently, the autonomy and empowerment central to recovery can be fostered.

Implications of Current Drama Therapy Approaches. As indicated in the literature, the majority of the current drama therapy approaches with adults with LD employ therapeutic theatre interventions, or involve performance-based interventions. While these interventions were considered to be beneficial in regard to social skills and self-esteem building (Bailey, 1993, 2009, 2010; Snow et al., 2003; Snow et al., 2017), they may not be the most befitting interventions for trauma treatment. Performance-based interventions pose the risk of exploitation. As a result, there exists the possibility of perpetuating problematic stigmas associated with the population (Goodley & Runswick-Cole, 2016), and subsequently risks “sensationalizing cultural differences” (Leavy, 2009, p. 151). Within the context of PTSD, this could be especially harmful given that trauma exists as such a profoundly personal experience (Herman, 1997). Thus, if therapeutic theatre or performance-based drama therapy interventions are to be used when treating PTSD in adults with LD, careful consideration must be taken of preparation of the material to be presented, the audience, and the participant's comfortability and capacity to tolerate sharing vulnerable stories in spaces that may not elicit desired, nor necessarily favorable, responses.

Treatment Recommendations. Given that exposure therapy has been identified as an effective form of PTSD treatment for adults with LD (Lemmon & Mizes, 2002), treatment for this population should implement methods rooted in exposure. The drama therapy method of DvT is perhaps most closely aligned with exposure-based methods (Pitre, Sajjani, & Johnson,

2015), and therefore presents as a favorable treatment option. Likewise, the potential “over-load” (Kroese et al., 2016, p. 306) is given a less threatening stage to perform upon due to elements of metaphor, spontaneity, creativity, and playfulness (Johnson, 2014). This thereby may decrease avoidance responses (Kroese et al., 2016) as individuals become desensitized to traumatic material within the safety of metaphor (Sajnani & Johnson, 2014). Accordingly, continued practice, or rehearsal, of these methods within the playspace may encourage resilience when presented with traumatic material in real life. In fact, DvT has clinically demonstrated higher retention rates within the first month of treatment in comparison to clients “in verbal-only trauma treatment” (Sajnani & Johnson, 2014, p. 26).

Nonetheless, DvT may not be the only favorable method of drama therapy to treat PTSD in adults with LD. Additional methods, such as the CANY model (Frydman & McLellan, 2014; Landis, 2014), role work (Hodermarska, Haen, & McLellan, 2014), and SEE FAR CBT (Lahad et al., 2010) also foster desensitization to traumatic material. Likewise, these methods may have the potential to improve executive functioning (EF), which could be especially beneficial given the preexisting cognitive differences of the population in addition to the EF changes which trauma elicits (Frydman & McLellan, 2014). However, additional research should be completed to determine which of these methods, or perhaps, which variety of methods, best suit the needs of the population. Thorough studies should be completed to assess needs of the population, necessary accommodations, and symptom reduction in response to employing drama therapy to treat PTSD in adults with LD. Ideally, future research could lead to outcome research employing drama therapy as treatment for the population.

Regardless of the drama therapy approach used, treatment with this population should also offer clear explanations and instructions. The aforementioned oppressed roles individuals

with LD are often placed in within society can invoke an impetuous facilitation of treatment, often accompanied with a disregard of the population's autonomy. In other words, the population, just like any other population, is ethically entitled to clear instructions, explanations, and rationale for treatment interventions. Thus, comprehensive, explicit, and ongoing informed consent is an important component of working this population (Gilderthorp, 2015). When executed justly, treatment has the potential to empower the population as opposed to hindering their autonomy.

Further Research. This literature review has intended to bring attention to an undertreated population, with the aims of facilitating conversation and awareness. It has also sought to offer direction in relation to treatment options befitting of the population. Likewise, this paper has discussed the potential drama therapy upholds as treatment for PTSD in adults with LD and has aimed to offer direction in navigating how to best support the population throughout treatment. Nonetheless, what is offered here is merely the beginning to what can be a promising continuation of work. Much continued research is necessary to determine the efficacy of drama therapy with this population, in addition to research that assesses best practices for the diverse nature of LD. Moreover, given the limited representation this population has previously received, it is important to ensure that adults with LD are receiving quality treatment, aligned with their specific needs, that is rooted in evidence-based practices.

Because LD manifest diversely, further research should assess the need for, and efficacy of any necessary accommodations within treatment. Adults with LD may demonstrate difficulty with verbal communication, limited social skills, restricted motor functioning, or all of the above (APA, 2013). Some adults with LD may rely on visual supports, while others may more easily access the playspace. Areas of further research should examine: the use of visual supports in the

playspace, the use of objects in the playspace (e.g. fidgets, sensory tools, and possibly projectives), and ways to modify instructions (e.g. the rap in DvT). Boorsma (2015) experimented with sensory modifications to traditional DvT practices when treating an adolescent with autism spectrum disorder (ASD). This was done by first using pool noodles within the playspace. By the closing phase of the case study, the pool noodles were no longer used, and the participant was able to successfully engage in the improvisational play characteristic of DvT. The goals of this case study were to increase the participant's social skills, and to improve the participant's functioning in the classroom environment. Upon the conclusion of the modified DvT interventions, the participant's functioning improved significantly (Boorsma, 2015). Boorsma's (2015) creativity in adapting traditional structures of DvT proved to be playfully advantageous. Although the treatment goals of this case study (Boorsma, 2015) are not necessarily aligned with trauma treatment, the benefits found from using sensory modifications in DvT practice may likewise benefit the treatment for PTSD in adults with LD. However, additional research is necessary to appropriately assess the specific adaptations and accommodations that would benefit the population.

Current research regarding PTSD for adults with LD has often employed practices commonly used with children (Dilly, 2014; Mevissen et al., 2011a; Mevissen et al., 2011b; Mevissen et al., 2012). Given that the verbal, communicative, and developmental functioning of adults with LD can look similar to that of children, there is some sensibility to these research choices. Likewise, PTSD symptoms in adults with LD have been found to manifest similarly to PTSD symptoms in children (Tomasulo & Raza, 2007). Given this, the choice to implement trauma treatment practices used with children when treating adults with LD is comprehensible. However, it may be adverse to assume that adults with LD would respond to treatment in the

same way as children, as this is arguably infantilizing to the population, and thus reinforces existing problematic stigmas (Koenig, 2012). Although examining PTSD treatment practices used with children may be helpful in informing PTSD treatment approaches for adults with LD, it is also critical to recognize the population as separate from children.

Conclusion

To move forward in offering effective PTSD treatment for adults with LD, we must confront the issues that confine society to a preservation of stigma. The historic disregard of trauma in adults with LD often presently feed messages of invisibility. Thus, the oppressed roles individuals with dis/abilities (Goodley & Runswick-Cole, 2016) are placed in by society are perpetuated, which subsequently sustains preexisting trauma roles. However, it is recognized that research on this population is still within its infancy (Prout & Nowak-Drabik, 2003). The increase in literature addressing PTSD in adults with LD within the past ten years is notable, as it is bringing attention to an oftentimes silenced population (Mevissen & de Jongh, 2010). Likewise, the existing literature is providing treatment options for PTSD in adults with LD, where previously treatment issues for this population would have been ignored.

This paper does not serve to disregard the progressive work that has been achieved so far. Rather, it serves to offer additional treatment approaches that may augment the recovery process and allow adults with LD to be provided with accessible, quality treatment for PTSD that most appropriately meets the needs of the population (Gilderthorp, 2015). Admittedly, much more research needs to be completed in regard to the population and best treatment practices. Altogether, this paper serves to offer a gathering of literature that may inform drama therapy practices moving forward.

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